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AUTHOR Safford, Florence
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ABSTRACT

The myth persists that the elderly are institutionalized because their relatives do not care enough about them. Nursing home staff may not respond to family members' concerns about their relatives with any better solutions than to take their relatives home. Family response to this lack of solution may be retreat or retaliation. Thus the institution and family are placed in an adversarial, rather than partnership, relationship. The family/institution relationship may be improved by: (1) exposing negative stereotypical attitudes held by staff about families; (2) sensitizing staff to the anxiety caused by the financial strain of long-term care; (3) training family, staff, and residents to understand the demands of the system and the roles and behavior required to ensure effective service; and (4) helping staff to recognize their unconscious guilt for being associated with a nursing home, a stigmatized social utility. Some excellent models of family programs and services are now available as guides. Following the principles suggested, and developing programs tailored to the individualized and cultural needs of the families, long-term care institutions can overcome the obstacles to family/staff partnerships by coordinating and linking their shared functions. (ABL)

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"If You Don't Like the Care, Why Don't You Take Your Mother Home?" : Obstacles to Family/Staff Partnerships in the Institutional Care of the Aged

by Florence Safford, DSW
Chair, Services to the Elderly
Social Work Department
Florida International University
North Miami, Florida 33181

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"If You Don't Like the Care, Why Don't You Take Your Mother Home?": Obstacles to Family/Staff Partnerships in The Institutional Care of the Aged.

In 1972, Stanley Cath wrote "The Institutionalization of a Parent __ A Nadir of Life," which vividly analyzed one of the most traumatic transitions which might occur in a lifetime. Since that milestone article, many specialists in long- term care have contributed to our growing recognition of the role of the family in the institutionalization of the elderly. (Brody, 1974 and in dozens of articles; Dobrof and Litwak 1977; Silverstone, 1982; Shore 1972). However the myth persists that families don't care enough for their elderly and that most people in institutions are there because the family has not behaved responsibly, or that they are without families.

A survey of more than forty textbooks on nursing home management and nursing home care revealed an almost total lack of reference to the family. This is a vivid articulation of the attitude that when an elderly person enters a long- term care facility, the institution takes over, and the family stays out of the way.

This paper examines several negative attitudes about the relationship of the family to the institutional staff, as expressed in the behavior and verbal exchanges between staff

and family members. The title is familiar to most staff who have direct contact with the families of their elderly residents.

The scenario is played out daily across the country, regardless of whether the institution is a private, for-profit facility, public, or non-profit voluntary; regardless of ethnic or religious affiliations; regardless of the socio-economic status of the actors involved. The frustrated relative voices concern about the lack of attention to problems experienced by the vulnerable relative. The clothing is constantly lost. The medication order hasn't been changed. The food is left uneaten on the tray. The aide neglected to get mother to the beautician for her appointment. Mother is left for too many hours in the geriatric chair. The litany is too familiar.

The nurse, supervisor, or administrator is also frustrated. He or she sincerely regrets that these problems continuously plague the institution despite the most up-to-date methods in applying scientific management techniques. The response, from a sophisticated member of the staff might be: "I can understand how you feel. And I wish we could give your mother the kind of individualized attention you want. But since we don't seem to be able to meet you wishes, if you don't like the care, why don't you take your mother home?"

A less sophisticated, or more frustrated and angry staff representative might omit the empathetic part of the game, and get right to the trump card: "If you don't like the care, why

don't you take your mother home?"

What is the typical family response? Given the overwhelmingly consistent evidence from every study of the pathway to institutionalization, that it is the decision after all other efforts at family care have failed, what can the response be? Either an impotent retreat, overcome by feelings of powerlessness and guilt, or angry retaliation, carrying the complaints higher in the chain of command or even outside the institution to the health department, ombudsman, or congressman!

This one example of the dynamics which can result in an adversarial relationship, rather than the preferred family/staff partnership model of care should underscore the need for reciprocal understanding and honest communication.

The paradoxical view of the family held by institutions is that (1) they've washed their hands of responsibility and have "dumped" their hard to mangage elderly on the nursing home staff, or (2) they are always around with complaints, and if they would get out of the way and let the staff do its job, everything would be fine. It's clear that the family gets blamed if they don't come often enough or if they come too often. The staff trump card in these situations is, "She only acts that way when you're here. When you're not here she gets along fine."

Another clue to the negative bias toward the family which staff members share is the frequently heard comment that when a

resident dies "The family suddenly appears out of the wood-work." Such commonly held notions expose the judgemental attitudes which stereotype families, ignoring their unique histories, strengths, and coping styles when confronted by the unanticipated challenges of institutionalization.

It is essential for the staff to become aware of these attitudes before they can begin to understand and deal with the pain and disorganization which characterize family behavior during the crisis of institutionalization. If Management values a partnership model of care, policies must lead to rules, services, and programs which welcome family involvement(Dobrof and Litwak 1977, Montgomery 1983, Edelson and Lyons 1985.)

Staff must also become sensitive to the anxiety caused by the financial stress of the high cost of long-term care, leading often to indigency or fear of indigency. The impact of finances on the decision-making process in long-term care is often overlooked, but it is frequently the most significant factor, until overwhelming physical and/or mental incapacity forces the nursing home placement. This stress, along with the anxiety and guilt related to separation can result in near panic. Families need skilled counseling and reassurance to work through these crises. (Safford, 1987)

Staff must also work on recognizing another possible source of some of their defensive behavior when families voice concerns or criticisms. This comes often from the stigma of being part of the "Nursing home industry." Nursing homes with

their history as asylums for paupers are commonly being viewed as "dumping grounds," or associated with so many scandals that the staff suffers from a "spoiled identity." (Eliopoulos, 1983) This is called to the surface each time a person working in a nursing home or adult congregate facility tells someone where they work, and find themselves qualifying the information with the apology, "but it's a good facility." This reveals an unconscious guilt and anxiety on the part of many members of the staff for their association with such a stigmatized social utility. These deep emotions come right to the surface when anxious families raise issues about the quality of care, and the immediate defense is to blame the family for expecting the institution to do what the family has failed to do.

If some of these unconscious reactions are recognized, the goal of sharing appropriately in caring for the residents can be more easily attained.

Institutional staffs, residents, and their families, all need training to understand the demands of the system and the roles and behavior required to ensure effective service. Special programs can facilitate the assumption of appropriate roles within the system, and support the collaboration of family and staff during the years of residency ahead, such as family councils, monthly educational programs, etc.

Some excellent models of family programs and services are now available as guides (Brody, 1974, Dobrof and Litwak, 1977; Mattson, 1978; Edelson and Lyons, 1985; Johnson and Grant,

1985; Solomon, 1982). Following the principles suggested, and developing programs tailored to the individualized and cultural needs of the families, long- term care institutions can overcome the obstacles to family/staff partnerships by coordinating and linking their shared functions.

Eliopoulos points out in her chapter, "Understanding Residents and Families" that the reactions of the family to having a relative in a nursing home depends upon a variety of factors, including: the family's health; the lifelong relationship among family members; the family's history of coping with crisis; the family's experience with and attitude towards nursing homes; beliefs about how the elderly should be treated, based on cultural and community influences; the competing demands of family members; and the family's ability to accept intervention from an outside source. The combination of these many variables leads inevitably to widely differing reactions, ranging from disengagement and depression, to oversolicitousness, unrealistic demands and unfounded criticism.

She goes on to provide the following practice wisdom:

"Not always always will families be passive, accepting, cooperative visitors who are least bothersome to the staff. Indeed, it is healthy that families consistently do not fill the "good visitor" mold, since it may require suppression of their own feelings. On the other hand, the family that complains incessantly and interacts with staff like enemies in battle serves no productive function for anyone, including

themselves. Staff must recognize that behaviors displayed by the family reflect the family's stress level and coping capacity at a given time. Care must be exercised to avoid overreacting to the behaviors of the family.

Helping the family members resolve their emotional conflicts and become active participants in the health care team can result in significant gains for staff, the family, and most important, the resident."(Eliopoulos, p.20)

Finally, Montgomery's study of institutional policies regarding family involvement provides another framework for analyzing the openness of the institution to the family. By studying such behaviors as "family recruitment," institutions can assess the extent of "co-orientation" of goals of staff and family (Montgomery, 1983).Honest exploration of the roles prescribed to family members as "client", "visitor" or "servant" (which entails expectations to provide technical assistance such as feeding and helping with clothing), can provide a basis for self-study regarding the impact on staff/family integration.

This overview of some of the dynamics of family and staff interactons is presented, based upon a belief that institutional employees, at all levels, would prefer an organizational climate which welcomes a balanced involvement of family members. Through recognition of some of the attitudinal biases and programmatic obstacles which interfere with a warm and caring institutional community, an authentic partnership can be achieved.

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